TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-59. General program exclusions - adults

The following are excluded from SoonerCare coverage for adults:

(1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(2) Services or any expense incurred for cosmetic surgery.

(3) Services of two physicians for the same type of service to the same ~~patient~~ member at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. ~~Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the patient's status.~~ If the consultant physician initiates treatment at the initial consultation and participates thereafter in the ~~patient's~~ member's care, the procedure codes for subsequent hospital care ~~should~~ must be used.

(4) Refractions and visual aids.

(5) ~~A separate payment for pre-operative care, if provided on the day before or the day of surgery, or for typical post-operative follow-up care~~ Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(6) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or ~~Reversal~~ reversal of sterilization procedures for the purposes of conception.

(7) ~~Non-therapeutic~~ Non-therapeutic hysterectomies. ~~Therapeutic hysterectomies require that the following information to be attached to the claim:~~

~~(A) a copy of an acceptable acknowledgment form signed by the patient, or,~~

~~(B) an acknowledgment by the physician that the patient has already been rendered sterile, or,~~

~~(C) a physician's certification that the hysterectomy was performed under a life-threatening emergency situation.~~

(8) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)

(9) Medical services considered ~~to be~~ experimental or investigational.

(10) Services of a Certified Surgical Assistant.

(11) Services of a Chiropractor. Payment is made for Chiropractor services on Crossover claims for coinsurance and/or deductible only.

(12) Services of an independent licensed Physical and/or Occupational Therapist.

(13) Services of a Psychologist.

(14) Services of an independent licensed Speech and Hearing Therapist.

(15) Payment for more than four outpatient visits per month (home~~,~~ or office~~, outpatient hospital~~) per ~~patient~~ member, except those visits in connection with family planning or related to emergency medical conditions.

(16) Payment for more than two nursing ~~home~~ facility visits per month.

(17) More than one inpatient visit per day per physician.

(18) Payment for removal of benign skin lesions unless medically necessary.

(19) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.

(20) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(21) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

(22) Mileage.

(23) A routine hospital visit on the date of discharge unless the member expired.

(24) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(25) Inpatient chemical dependency treatment.
(26) Fertility treatment.
(27) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

317:30-3-60. General program exclusions - children

(a) The following are excluded from ~~Medicaid~~ SoonerCare coverage for children:

(1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(2) Services or any expense incurred for cosmetic surgery~~,~~ unless the physician certifies the procedure emotionally necessary ~~for the emotional well-being of the patient~~.

(3) Services of two physicians for the same type of service to the same ~~patient~~ member at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. ~~Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the patient's status.~~ If the consultant physician initiates treatment at the initial consultation and participates thereafter in the ~~patient's~~ member's care, the procedure codes for subsequent hospital care ~~should~~ must be used.

(4) ~~Separate payment for post-operative care when payment is made for surgery~~ Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(5) Sterilization of ~~persons~~ members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(6) ~~Hysterectomy, unless therapeutic and unless a copy of an acknowledgment form, signed by the patient or an acknowledgment by the physician that the patient has already been rendered sterile is attached to the claim~~ Non-therapeutic hysterectomies.

(7) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (See OAC 317:30-5-6 or 317:30-5-50).
(8) Medical services considered ~~to be~~ experimental or investigational.
(9) Services of a Certified Surgical Assistant.
(10) Services of a Chiropractor.
~~(11) Services of a Registered Physical Therapist.~~
~~(12)~~ (11) More than one inpatient visit per day per physician.
(12) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
(13) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
(14) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
(15) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(16) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(17) Mileage.
(18) A routine hospital visit on date of discharge unless the member expired.

(b) Not withstanding the exclusions listed in (1)-~~(12)~~ (18) of subsection (a), the Early and Periodic, Screening, Diagnosis and Treatment Program (EPSDT) provides for coverage of needed medical services normally outside the scope of the medical program when performed in connection with an EPSDT screening and prior authorized.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

317:30-5-2. General coverage by category

(a) **Adults.** Payment for adults is made to physicians for medical and surgical services within the scope of the Oklahoma Health Care Authority's (OHCA's) SoonerCare program, provided the services are reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Coverage of certain services must be based on a determination made by the OHCA's medical consultant in individual circumstances.

(1) Coverage includes the following medically necessary services:

(A) Inpatient hospital visits for all SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.

(B) Inpatient psychotherapy by a physician.

(C) Inpatient psychological testing by a physician.

(D) One inpatient visit per day, per physician.

(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgery center (ASC) or a Medicare certified hospital that offers outpatient surgical services. Refer to the Medicare approved list of covered services that can be performed at an ASC ~~List of Covered Surgical Procedures~~.

(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for members with proven malignancies or opportunistic infections.

(G) Direct physician services on an outpatient basis. A maximum of four visits are allowed per month per member in office or home regardless of the number of physicians providing treatment. Additional visits per month are allowed for those services related to emergency medical conditions and for services in connection with Family Planning.

(H) Direct physician services in a nursing facility for those members residing in a long-term care facility. A maximum of two nursing facility visits per month are allowed. To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare ~~patient~~ member, attach the EOMB from Medicare showing denial and mark "carrier denied coverage".

(I) Diagnostic x-ray and laboratory services.

(J) Mammography screening and additional follow-up mammograms.

(K) Obstetrical care.
(L) Pacemakers and prostheses inserted during the course of a surgical procedure.
(M) Prior authorized examinations for the purpose of determining medical eligibility for programs administered by OHCA. A copy of the authorization, OKDHS form 08MA016E, Authorization for Examination and Billing, must accompany the claim.
(N) If a physician renders direct care to a member on the same day as a dialysis treatment, payment is allowed for a separately identifiable service unrelated to the dialysis.
(O) Family planning includes sterilization procedures for legally competent members 21 years of age and over who voluntarily request such a procedure and, executes the federally mandated consent form with his/her physician. A copy of the consent form must be attached to the claim form. Separate payment is allowed for ~~I.U.D. insertion~~ the insertion and/or implantation of contraceptive devices during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception is not allowed. Reversal of sterilization procedures are allowed when medically indicated and substantiating documentation is attached to the claim.
(P) Genetic counseling ~~(requires special medical review prior to approval)~~.
~~(Q) Weekly blood counts for members receiving the drug Clozaril.~~
~~(R) Complete blood count (CBC) and platelet count prior to receiving chemotherapeutic agents, radiation therapy or medication such as DPA-D-Penacillamine on a regular basis for treatment other than for malignancy.~~ (Q) Laboratory testing (such as complete blood count (CBC), platelet count, or urinalysis) for monitoring members receiving chemotherapy, radiation therapy, or medications that require monitoring during treatment.
~~(S)~~ (R) Payment for ultrasounds for pregnant women as specified in OAC 317:30-5-22.
~~(T)~~ (S) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the member in conformity with federal regulations.

~~(U)~~ (T) Payment to clinical fellow or chief resident in an outpatient academic setting when the following conditions are met:

(i) Recognition as clinical faculty with participation in such activities as faculty call, faculty meetings, and having hospital privileges;

(ii) Board certification or completion of an accredited residency program in the fellowship specialty area;

(iii) Hold unrestricted license to practice medicine in Oklahoma;

(iv) If Clinical Fellow, practicing during second or subsequent year of fellowship;

(v) Seeing members without supervision;

(vi) Services provided not for primary purpose of medical education for the clinical fellow or chief resident;

(vii) Submit billing in own name with appropriate Oklahoma SoonerCare provider number.

(viii) Additionally if a clinical fellow practicing during the first year of fellowship, the clinical fellow must be practicing within their area of primary training. The services must be performed within the context of their primary specialty and only to the extent as allowed by their accrediting body.

~~(V)~~ (U) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met.

(i) Attending physician performs chart review and ~~sign~~ signs off on the billed encounter;

(ii) Attending physician is present in the clinic/or hospital setting and available for consultation;

(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

~~(W)~~ (V) Payment to the attending physician for the outpatient services of an unlicensed physician in a training program when the following conditions are met:

(i) The member must be at least minimally examined by the attending physician or a licensed physician under the supervision of the attending physician;

(ii) The contact must be documented in the medical record.

~~(X)~~ (W) The payment to a physician for medically directing the services of a CRNA or for the direct supervision of the services of an Anesthesiologist Assistant (AA) is limited. The maximum allowable fee for the services of both providers combined is limited to the maximum allowable had the service been performed solely by the anesthesiologist.

~~(Y)~~ (X) One pap smear per year for women of child bearing age. Two follow-up pap smears are covered when medically indicated.

~~(Z)~~ (Y) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adult are covered services based upon the conditions listed in (i)-(iv) of this subparagraph:

(i) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.

(ii) To be prior authorized all procedures are reviewed based on appropriate medical criteria.

(iii) To be compensable under the SoonerCare program, all organ transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.

(iv) Procedures considered experimental or investigational are not covered.

~~(AA)~~ (Z) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

(i) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure.

(ii) Donor expenses that occur after the 90 day global reimbursement period must be submitted to the OHCA for review.

~~(BB)~~ (AA) Total parenteral nutritional therapy (TPN) for identified diagnoses and when prior authorized.

~~(CC)~~ (BB) Ventilator equipment.

~~(DD)~~ (CC) Home dialysis equipment and supplies.

~~(EE)~~ (DD) Ambulatory services for treatment of members with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and prescriptions. Drugs prescribed for the treatment of TB beyond the prescriptions covered under SoonerCare

require prior authorization by the University of Oklahoma College of Pharmacy Help Desk using form "Petition for TB Related Therapy". Ambulatory services to members infected with TB are not limited to the scope of the SoonerCare program, but require prior authorization when the scope is exceeded.

~~(FF)~~ (EE) Smoking and Tobacco Use Cessation Counseling for treatment of individuals using tobacco.

(i) Smoking and Tobacco Use Cessation Counseling consists of the 5As:

(I) Asking the member to describe their smoking use;

(II) Advising the member to quit;

(III) Assessing the willingness of the member to quit;

(IV) Assisting the member with referrals and plans to quit; and

(V) Arranging for follow-up.

(ii) Up to eight sessions are covered per year per individual.

(iii) Smoking and Tobacco Use Cessation Counseling is a covered service when performed by physicians, physician assistants, advanced registered nurse practitioners, certified nurse midwives, dentists, and Oklahoma State Health Department and FQHC nursing staff. It is reimbursed in addition to any other appropriate global payments for obstetrical care, PCP care coordination payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

(iv) Chart documentation must include a separate note and signature along with the member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

~~(GG)~~ (FF) Immunizations as specified by the Advisory Committee on Immunization Practices (ACIP) guidelines.

(2) General coverage exclusions include the following:

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery.
(C) Services of two physicians for the same type of service to the same member at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. ~~Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the member's status.~~ If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member's care, the procedure codes for subsequent hospital care must be used.
(D) Refractions and visual aids.
(E) ~~A separate payment for pre-operative care, if provided on the day before or the day of surgery, or for typical post-operative follow-up care~~ Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).
(F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
(G) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
(H) Non-therapeutic ~~hysterectomy~~ hysterectomies.
(I) Medical services considered experimental or investigational.
(J) Payment for more than four outpatient visits per month (home or office) per member, except those visits in connection with family planning~~,~~ or related to emergency medical conditions.
(K) Payment for more than two nursing facility visits per month.
(L) More than one inpatient visit per day per physician.
~~(M) Physician supervision of hemodialysis or peritoneal dialysis.~~

~~(N)~~ (M) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.

~~(O)~~ (N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

~~(P)~~ (O) Payment for the services of ~~physicians' assistants,~~ social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

~~(Q)~~ (P) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury~~,~~ or illness, ~~related to~~ including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or ~~when~~ that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)

~~(R) Night calls.~~

~~(S)~~ (Q) Speech and Hearing services.

~~(T)~~ (R) Mileage.

~~(U)~~ (S) A routine hospital visit on the date of discharge unless the member expired.

~~(V)~~ (T) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

~~(W)~~ (U) Inpatient chemical dependency treatment.

~~(X)~~ (V) Fertility treatment.

~~(Y)~~ (W) Payment for removal of benign skin lesions unless medically necessary.

(b) **Children.** Payment is made to physicians for medical and surgical services for members under the age of 21 within the scope of the Authority's SoonerCare program, provided the services are medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. In addition to those services listed for adults, the following services are covered for children.

(1) **Pre-authorization of inpatient psychiatric services.** All inpatient psychiatric services for members under 21 years of age must be prior authorized by an agency designated by the Oklahoma Health Care Authority. All

psychiatric services are prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services are not SoonerCare compensable.

(A) All residential and acute psychiatric services are authorized based on the medical necessity criteria as described in OAC 317:30-5-95.25,317:30-5-95.27 and 317:30-5-95.29.

(B) Out of state placements are not authorized unless it is determined that the needed medical services are more readily available in another state or it is a general practice for members in a particular border locality to use resources in another state. If a medical emergency occurs while a member is out of the State, treatment for medical services is covered as if provided within the State. A prime consideration for placements is proximity to the family or guardian in order to involve the family or guardian in discharge and reintegration planning.

(2) **General acute care inpatient service limitations.** All general acute care inpatient hospital services for members under the age of 21 are not limited. All inpatient care must be medically necessary.

(3) **Procedures for requesting extensions for inpatient services.** The physician and/or facility must provide necessary justification to enable OHCA, or its designated agent, to make a determination of medical necessity and appropriateness of treatment options. Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment in accordance with the medical necessity criteria described in OAC 317:30-5-95.26, 317:30-5-95.28 and 317:30-5-95.30. Requests must be made prior to the expiration of the approved inpatient stay. All decisions of OHCA or its designated agent are final.

(4) **Utilization control requirements for psychiatric beds.** Utilization control requirements for inpatient psychiatric services for members under 21 years of age apply to all hospitals and residential psychiatric treatment facilities.

(5) **Early and periodic screening diagnosis and treatment program.** Payment is made to eligible providers for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of members under age 21. These services include medical, dental, vision, hearing and other necessary

health care. Refer to OAC 317:30-3-65.2 through 317:30-3-65.11 for specific guidelines.

(6) **Child abuse/neglect findings.** Instances of child abuse and/or neglect discovered through screenings and regular exams are to be reported in accordance with State Law. Section 7103 of Title 10 of the Oklahoma Statutes mandates reporting suspected abuse or neglect to the Oklahoma Department of Human Services. Section 7104 of Title 10 of the Oklahoma Statutes further requires reporting of criminally injurious conduct to the nearest law enforcement agency.

(7) **General exclusions.** The following are excluded from coverage for members under the age of 21:

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.

(C) Services of two physicians for the same type of service to the same member at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. ~~Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the member's status.~~ If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member's care, the procedure codes for subsequent hospital care must be used.

(D) ~~A separate payment for pre-operative care, if provided on the day before or the day of surgery, or for typical post-operative follow-up care~~ Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(F) Sterilization of ~~persons~~ members who are under 21 years of age, mentally incompetent, or

procedures for the purposes of conception.

(G) ~~Non-therapeutic hysterectomy.~~ Non-therapeutic hysterectomies.

(H) Medical Services considered experimental or investigational.

(I) More than one inpatient visit per day per physician.

(J) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)

~~(K) Physician supervision of hemodialysis or peritoneal dialysis.~~

~~(L)~~ (K) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.

~~(M)~~ (L) Payment for the services of ~~physicians' assistants~~ social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

~~(N)~~ (M) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

~~(O)~~ (N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

~~(P) Night calls.~~

~~(Q)~~ (O) Mileage.

~~(R)~~ (P) A routine hospital visit on date of discharge unless the member expired.

~~(S) Tympanometry.~~

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the OHCA allowable for comparable services. Claims filed with Medicare Part B should automatically cross over to OHCA. The explanation of Medicare Benefits (EOMB) reflects a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with the OHCA within 90 days of the date of Medicare

payment or within one year of the date of service in order to be considered timely filed.

(1) In certain circumstances, some claims do not automatically "cross over". Providers must file a claim for coinsurance and/or deductible to SoonerCare within 90 days of the Medicare payment or within one year from the date of service.

(2) If payment was denied by Medicare Part B and the service is a SoonerCare covered service, mark the claim "denied by Medicare" and attach the Medicare EOMB showing the reason for the denial.

317:30-5-9. Medical services

(a) **Use of medical modifiers**. The Physicians' Current Procedural Terminology (CPT) and the second level HCPCS provide for 2-digit medical modifiers to further describe medical services. Modifiers are used when appropriate.

(b) **Covered office services.**

(1) Payment is made for four office visits (or home) per month per member, for adults (over age 21), regardless of the number of physicians involved. Additional visits per month are allowed for services related to emergency medical conditions.

(2) Visits for the purpose of family planning are excluded from the four per month limitation.

(3) Payment is allowed for ~~insertion of IUD~~ the insertion and/or implantation of contraceptive devices in addition to the office visit.

(4) Separate payment will be made for the following supplies when furnished during a physician's office visit.

(A) Casting materials

(B) Dressing for burns

(C) ~~Intrauterine device~~ Contraceptive devices

(D) IV Fluids

~~(E) Medications administered by IV~~

~~(F) Glucose administered IV in connection with chemotherapy in office~~

(5) Payment is made for routine physical exams only as prior authorized by the OKDHS and are not counted as an office visit.

(6) Medically necessary office lab and X-rays are covered.

(7) Hearing exams by physician for members between the ages of 21 and 65 are covered only as a diagnostic exam to determine type, nature and extent of hearing loss.

(8) Hearing aid evaluations are covered for members under 21 years of age.
(9) IPPB (Intermittent Positive Pressure Breathing) is covered when performed in physician's office.
(10) Payment is made for both an office visit and an injection of joints performed during the visit if the joint injection code does not have a global coverage designation.
(11) Payment is made for an office visit in addition to allergy testing.
(12) Separate payment is made for antigen.
(13) Eye exams are covered for members between ages 21 and 65 for medical diagnosis only.
(14) If a physician personally sees a member on the same day as a dialysis treatment, payment can be made for a separately identifiable service unrelated to the dialysis.
(15) Separate payment is made for the following specimen collections:
(A) Catheterization for collection of specimen; and
(B) Routine Venipuncture.
(16) The Professional Component for electrocardiograms, electroencephalograms, electromyograms, and similar procedures are covered on an inpatient basis as long as the interpretation is not performed by the attending physician.
(17) Cast removal is covered only when the cast is removed by a physician other than the one who applied the cast.

(c) **Non-covered office services.**

(1) Payment is not made separately for an office visit and rectal exam, pelvic exam or breast exam. Office visits including one of these types of exams should be coded with the appropriate office visit code.
(2) Payment cannot be made for prescriptions or medication dispensed by a physician in his office.
(3) Payment will not be made for completion of forms, abstracts, narrative reports or other reports, separate charge for use of office or telephone calls.
(4) Additional payment will not be made for ~~night calls, unusual hours or~~ mileage.
(5) Payment is not made for an office visit where the member did not keep appointment.
(6) Refractive services are not covered for persons between the ages of 21 and 65.
(7) Removal of stitches is considered part of post-operative care.

(8) Payment is not made for a consultation in the office when the physician also bills for surgery.

(9) Separate payment is not made for oxygen administered during an office visit.

(d) **Covered inpatient medical services.**

(1) Payment is allowed for inpatient hospital visits for all SoonerCare covered admissions. Psychiatric admissions must be prior authorized.

(2) Payment is allowed for the services of two physicians when supplemental skills are required and different specialties are involved. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. ~~Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the member's status.~~ If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member's care, the procedure codes for subsequent hospital care ~~are~~ must be used.

(3) Certain medical procedures are allowed in addition to office visits.

(4) Payment for critical care is all-inclusive and includes payment for all services that day. Payment for critical care, first hour is limited to one unit per day ~~and 4 units per month~~. ~~Payment for critical care, each additional 30 minutes is limited to two units per day/month.~~

(e) **Non-covered inpatient medical services.**

(1) For inpatient services, all visits to a member on a single day are considered one service except where specified. Payment is made for only one visit per day.

(2) A hospital admittance or visit and surgery on the same day would not be covered if post-operative days are included in the surgical procedure. If there are no post-operative days, a physician can be paid for visits.

(3) Drugs administered to inpatients are included in the hospital payment.

(4) Payment will not be made to a physician for an admission or new patient work-up when the member receives surgery in out-patient surgery or ambulatory surgery center.

(5) Payment is not made to the attending physician for interpretation of tests on his own patient.

(f) **Other medical services.**

(1) Payment will be made to physicians providing Emergency Department services.
(2) Payment is made for two nursing ~~home~~ facility visits per month. The appropriate CPT code is used.
(3) When payment is made for "Evaluation of arrhythmias" or "Evaluation of sinus node", the stress study of the arrhythmia includes inducing the arrhythmia and evaluating the effects of drugs, exercise, etc. upon the arrhythmia.
(4) When the physician bills twice for the same procedure on the same day, it must be supported by a written report.

317:30-5-20. Laboratory services

This Section covers the guidelines for payment of laboratory services by a provider in his/her office, a certified laboratory and for a pathologist's interpretation of laboratory procedures.

(1) **Covered lab services.** Providers may be paid for covered clinical diagnostic laboratory services only when they personally perform or supervise the performance of the test. If a provider refers specimen to a certified laboratory or a hospital laboratory serving outpatients, the certified laboratory or the hospital must bill for performing the test.

(A) ~~Effective September 1, 1992, reimbursement~~ Reimbursement for lab services is made in accordance with the Clinical Laboratory Improvement Amendment of 1988 (CLIA). These regulations provide that payment may be made only for services furnished by a laboratory that meets CLIA conditions, including those furnished in physicians' offices. Eligible providers must be certified under the CLIA program and have obtained a CLIA ID number from HCFA and have a current contract on file with the OHCA. Payment is made only for those services which fall within the approved specialties/subspecialties.

(B) ~~Effective May 1, 1993, reimbursement~~ Reimbursement rate for laboratory procedures is the lesser of the HCFA National 60% fee or the local carrier's allowable (whichever is lower).

(C) All claims for laboratory services are considered medically necessary unless specifically disallowed in this Chapter.

(2) **Compensable outpatient laboratory services.** Medically necessary laboratory services are covered.

~~Genetic counseling requires special medical review prior to approval.~~

(3) **Noncompensable laboratory services.**

(A) Separate payment is not made for blood specimens obtained by venipuncture or urine specimens collected by a laboratory. These services are considered part of the laboratory analysis.

(B) Claims for inpatient full service laboratory procedures are not covered since this is considered a part of the hospital rate.

(4) **Covered services by a pathologist.**

(A) A pathologist may be paid for interpretation of inpatient surgical pathology specimen. The appropriate CPT procedure code and modifier is used.

(B) Full service or interpretation of surgical pathology for outpatient surgery performed in an outpatient hospital or Ambulatory Surgery Center setting.

(5) **Non-compensable services by a pathologist.** The following are non-compensable pathologist services:

(A) Tissue examinations for identification of teeth and foreign objects.

(B) Experimental or investigational procedures.

(C) Interpretation of clinical laboratory procedures.

PART 3. HOSPITALS

317:30-5-42.17. Non-covered services

In addition to the general program exclusions [OAC 317:30-5-2(a)(2)] the following are excluded from coverage:

(1) Inpatient <u>admission for</u> diagnostic studies that could be performed on an outpatient basis.

(2) Procedures that result in sterilization which do not meet the guidelines set forth in this Chapter of rules.

(3) Reversal of sterilization procedures for the purposes of conception are not covered.

(4) Medical services considered ~~to be~~ experimental <u>or investigational</u>.

(5) Payment for removal of benign skin lesions unless medically necessary.

(6) Refractions and visual aids.

(7) Charges incurred while ~~patient~~ <u>the member</u> is in a skilled nursing or swing bed.